Health Care Quality Concern Form

TriWest Healthcare Alliance Department of Veterans Affairs (VA) Programs

Instructions

Please complete this form if you have a concern regarding the **quality of health** care performed by a TriWest provider. If you have a complaint regarding staff rudeness, cleanliness of office, wait time in office, discrimination, etc., please complete the Complaint/Grievance form.

TriWest Healthcare Alliance
Clinical Quality Management
P.O. Box 41970 Phoenix, AZ 85080-1970

Email: MMOPSCQM@TriWest.com
Fax: (866) 299-4235

Person Completing Information

First Name: _____ Last Name: _____

Telephone: _____ Email: _____

Relationship to Veteran: Self ☐ Family/Caregiver ☐ Provider ☐ VA/VA Medical Center ☐ Other ☐ List Other: _____

Veteran Information

First Name: _____ Last Name: _____

Date of Birth: _____ Last Four of SSN: _____

Telephone Number: _____ Member ID: _____

Email Address (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Quality of Health Care Concern

Health Care Provider's Name (if applicable): _____

Health Care Provider's Address (if known): _____

Date(s) of Incident(s): _____

Describe your concern(s): Please be as specific as possible about the nature of your concerns. We will contact you if more information is needed. You may attach additional pages or supporting documentation.

Signature: _____ Date: _____

Please be assured that TriWest takes all concerns seriously and will thoroughly investigate the matter and take all appropriate actions. Due to federal and/or state privacy regulations, we are unable to share the results of our investigation or actions taken as it pertains to a clinical quality program.